No. 80-802

ALEXANDER L
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, *Petitioner,*

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION, *Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY BRIEF FOR THE PETITIONER

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The fatal flaw in the decision of the court below is found in a single sentence of its opinion, where the court said (628 F.2d at 1055; J.A. at 207(a)):

> Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency.

The fact is that MAHSA had no certificate of need authority. Such powers were given by the Act only to a State Health Planning and Development Agency (under 42 U.S.C. §§300m *et seq.* — *see* Appendix to this Brief at 8a), and Missouri had not designated such an agency during the period here in question.

This confusion between the regulatory powers given by the statute to State Health Planning and Development Agencies and the reporting and recommending functions assigned to Health Systems Agencies (*see* 42 U.S.C.

§300*l*-1(b)(1) and §300*l*-2(b), (f), and (g), set out in the Appendix to this Brief at 1a-4a), permeates the respondents' brief. It has led respondents into a line of argument which can be summarized as follows: Congress in 1974 created a two-track scheme of (1) public regulation, using a complicated bureaucracy of federal, state and private groups and enforced through state certificate of need laws and, at the same time, (2) cartel regulation, using local private planning agencies acting in "cooperation" with other private entities. The former was fully debated and carefully designed to place all regulatory powers with public agencies, leaving to private groups only the role of gathering information and making recommendations, with clear lines of review and appeal to the Secretary of HEW (now HHS) and the courts. The latter was never even discussed, and no effort was made to supply due process or other procedural protections or any avenues of administrative or judicial review.

This creative interpretation of the 1974 Act is essential to respondents' position. Only if Congress mandated a system of regulation through wholly private action can it even be argued that repeal of the antitrust laws is "necessary to make [the Act] work." *Silver* v. *New York Stock Exchange,* 373 U.S. 341, 357. But Congress did not turn to self-help in 1974; instead it established a balanced system of regulation *by the States.* Far from approving purely private regulation, Congress was careful to withhold *any* regulatory power from all but public agencies. In 1979, when it reexamined the 1974 Act, Congress explicitly rejected numerous suggestions to grant private actors the antitrust immunity respondents argue was implicit in the 1974 Act. In sum, neither the legislative history of the 1974 Act or its 1979 amendments nor a sense of the legislative process support the

conclusion that Congress ever intended to repeal the antitrust laws in the health care industry, and to do it wholly by implication.

I. CONGRESS DID NOT INTEND TO ESTABLISH A SYSTEM OF PRIVATE CARTEL REGULATION.

The 1974 Health Planning Act was a substantial venture, pulling together various programs enacted over the years and, together with new ideas, molding those separate and to some extent inconsistent efforts into "a single new program of State and area-wide health planning." S. Rep. No. 1285, 93d Cong., 2d Sess. 2, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7843. Respondents' selective description of the background leading up to the 1974 Act, and their reliance on very limited portions of the Act, do not do justice to what was a complex effort to reach a "delicate but workable balance among the varied interests operating in the health care industry." S. Rep. No. 1285, 93d Cong., 2d Sess. 52, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7891.

Previous efforts at health planning had been "only marginally successful" because of "inadequately specific Congressional mandate[s] . . . , inadequate funding, and inadequate authority to implement recommendations." S. Rep. No. 1285, 93d Cong., 2d Sess. 40, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7879. The 1974 Planning Act was designed to meet these problems through the creation of an elaborate structure of several tiers of public and private entities (including representatives of all affected and competing interests), *and* the establishment of a regulatory system under the authority of the States. These were integral parts of a single whole; respondents' attempt to segregate them into parallel —

but separate — "tracks" mischaracterizes the legislation's structure and purpose.[1]

The planning structure included, at the top, a National Council on Health Planning and Development (42 U.S.C. §300k-3), and Statewide Health Coordinating Councils (42 U.S.C. §300m-3). In between were State Health Planning and Development Agencies (SHPDAs), which had to be agencies of State government with appropriate governmental powers. 42 U.S.C. §300m. At the bottom were Health Systems Agencies (HSAs), whose composition was carefully prescribed to include all relevant interest groups. 42 U.S.C. §300*l*-1. The 1974 Act also called for the establishment of centers for multidisciplinary health planning development and assistance, and for the creation of a national health planning information center. 42 U.S.C. §§300n-2(c), 300n-3.

The HSA was given grass roots responsibilities. As described by the Senate Report, these included "the accumulation of data in order to assess the existing status of the health care delivery system in the area it serves, and . . . developing short and long-term recommendations in order to achieve the rational and equitable distribution of personal health care services throughout its planning area." S. Rep. No. 1285, 93d Cong., 2d Sess. 44-45, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7884.[2] It is clear, though, that Congress did

[1] Throughout their brief, respondents use the term "planning" as though it were synonymous with cartel regulation. But there is no indication that Congress had this understanding. In fact, the term "planning agencies" is generally used in the legislative history to include all the bodies — public and private — involved in the planning process. *See, e.g.*, H.R. Rep. No. 1382, 93d Cong., 2d Sess. 33-34 (1974).

[2] The HSAs were not intended to focus primarily on new hospital construction. Indeed, the HSA may engage in many modes of

not intend that HSAs should have any regulatory power. The 1974 Senate Report explains why:

> Although the keystone to the health planning effort envisioned in the proposed Committee legislation is the areawide health planning agency, certain functions are more appropriately performed at the State level. Specifically, the integration and synthesis of areawide health plans into a Statewide health plan, the establishment of priorities within the State, and the performance of regulatory functions are most appropriately carried out at the State level. *The latter function can appropriately be carried out only by an agency of State government.* [S. Rep. No. 1285, 93d Cong., 2d Sess. 52, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7891; emphasis added.][3]

The "regulatory functions" referred to were intended to provide the sanctions that had been missing from earlier planning legislation. Thus, Congress required that

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"implementing" its Plans with the assistance of other parties which, unlike the situation in the present case, have no antitrust implications. For example, the HSA might, in its Plan, identify a need for a Trauma Center or a special emergency medicine facility in its health service area, and work with an academic medical center in the area to establish such a center. Or it might identify the need for a new category of health care personnel, or increasing numbers of existing categories of health manpower, to achieve the goals set forth in its Plan, and work with a junior college in its area to help establish training programs for such personnel. In short, respondents' contention that the "references to 'implementation' in the 1974 Act would have been meaningless" (R. Br. at 30) if the conduct under attack here is not permitted is quite unfounded.

[3] *See also* H.R. Rep. No. 1382, 93d Cong., 2d Sess. 65 (1974): "[T]he Committee feels that regulatory activities are appropriately vested in units of public government." This conclusion was reiterated in the 1979 Senate Report, S. Rep. No. 96, 96th Cong., 1st Sess. 67, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1372.

each State, on pain of loss of various federal funds, should create a regulatory program with certain mandatory features:

(1) It must be administered by "an agency . . . of the government of that State" (42 U.S.C. §300m(b)(1));

(2) The State Health Planning and Development Agency (SHPDA) must be the "sole agency for the performance" of the functions required of the SHPDA (42 U.S.C. §300m-1(b)(1));

(3) The SHPDA must have "under State law the authority to carry out such functions" (42 U.S.C. §300m-1(b)(2));

(4) The SHPDA must "(A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public" (42 U.S.C. §300m-1(b)(6)).

The SHPDA was required to "[c]onduct the health planning activities of the State" (42 U.S.C. §300m-2(a)(1)), including administering the State certificate of need program. Again on the pain of losing various federal funds, each State was required to "provide for review and determination of need" for new institutional health services, a program described by the 1979 Senate Report as the "basic component" of the health planning process. S. Rep. No. 96, 96th Cong., 1st Sess. 5, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1310. In making those determinations, the SHPDA was required to consider — but not necessarily follow — recommendations made by health systems agencies. 42 U.S.C. §300m-2(a)(5).

Respondents argue that there are really two schemes, one "regulatory" and one "planning" — alter-

native methods of reaching the same result. But this construction is incompatible with the language of Congress and the statute it passed. It would be incongruous at best for the Congress that believed that regulatory functions "can appropriately be carried out only by an agency of state government", and which displayed considerable concern about possible conflicts of interests,[4] to create at the same time a system of collusive and perhaps coercive regulation by HSAs and private entities. And it would be senseless to create a carefully-circumscribed procedure of public regulation while simultaneously encouraging private cartel decision-making with no due process protections, no right of appeal — indeed, no right or even expectation that the public would have any idea what deals had been struck, what agreements

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[4] In 1974, the Senate Report noted concerns about conflicts of interests of providers and concluded that "their influence on the health planning process must be appropriately limited." S. Rep. No. 1285, 93d Cong., 2d Sess. 46, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7886. The Senate Report went on to state that

> [I]t wishes to make clear its concern about potential conflicts of interest resulting from support of the activities of the health planning agency by local hospital associations, medical societies, health insurers, or others with a direct financial interest in the provision of health care services. The Committee has provided an appropriate channel of expression for those interests by requiring that they be represented on the health planning agencies' governing body. By including a provision dealing with funding of the health planning agencies, the Committee wishes to preclude the exercise of undue influence by providers. . . ." [S. Rep. No. 1285, 93d Cong., 2d Sess. 47, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7887.]

Because of these concerns, the 1974 Act prohibited funding of HSAs by providers. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, §1512(b)(5), 88 Stat. 2235 (1974).

reached, what competitive initiative stifled by persuasion or coercion.[5]

Respondents argue that the 1974 Act "has a policy basis quite distinct from . . . traditional regulatory provisions." R. Br. at 39. If respondents' interpretation of the Act is correct, this would be a considerable understatement. Respondents would have us believe that Congress, with 28 words in a statute over 55 printed pages in length, intended to cast aside over 90 years of jurisprudence and adopt a dramatic new approach to economic regulation.[6] To imagine that Congress would take such a step without one word of debate is fanciful.

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[5] Respondents argue that, even under their interpretation of the Planning Act, petitioner could have sought review of the MAHSA HSP, or attempted to attack the renewal of MAHSA's grant from HEW. R. Br. at 40. By this reasoning, the opportunity to seek changes in legislative standards would render unnecessary rights of appeal for adjudicative decisions. This is a novel doctrine of administrative law which would certainly attract considerable attention if broadly advanced. Even in this fact situation, however, the notion falls of its own weight. It is hardly practical for a single new hospital to carry the burden of attacking the entire HSP, or the HSA's overall performance, when the issue is what amounts to a single adjudicative decision made by private parties. As pointed out in our Brief (Pet. Br. at 33 n. 30), this Court has often identified the lack of opportunity for judicial review as a basis for determining whether implied repeal is appropriate. In this fact situation, the instant litigation is the only realistic opportunity for any judicial review of respondents' conduct.

[6] Even some of these 28 words are superfluous, according to respondents. They interpret the phrase "to the extent practicable" as merely indicating Congressional recognition of the limits on the ability of the HSA to elicit cooperation. R. Br. at 25 n. 20. It seems more likely, as we argue in our Brief (Pet. Br. at 20-21), that this phrase recognizes limits on the kind of "assistance" private parties could legally render. Nevertheless, accepting *arguendo* respondents' interpretation, this further illustrates the frail foundation on which this "special species of regulation" rests. R. Br. at 26.

II. THE 1979 AMENDMENTS ARE INCONSISTENT WITH RESPONDENTS' POSITION.

In 1977, Congress began to reexamine the 1974 Planning Act. Legislation was passed by the Senate in 1978, but was not then acted upon by the House. Finally, in 1979 Congress passed the Health Planning and Resources Development Amendments of 1979 ("1979 Amendments").

The 1979 Amendments were an attempt to build on the 1974 Act — an attempt to "strengthen [the planning process as envisioned in the 1974 Act] — not disrupt it." S. Rep. No. 96, 96th Cong., 1st Sess. 67, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1372. Thus, the debates in 1979 and the legislation which resulted are quite instructive as to the purpose of Congress just five years earlier. Respondents are nevertheless unenthusiastic about the use of the 1979 Amendments as a guide to Congressional intent in 1974, and with good reason: Antitrust questions were substantial issues during the debates on the 1979 Amendments, but those debates provide no support for an implied repeal argument. In fact, the debates clearly show that all involved in 1979 — Congress, HEW and private entities — would have been quite surprised to hear that Congress had already impliedly repealed the antitrust laws in this area, as the respondents contend here.

The first witness in the hearings on the 1979 Amendments before the House Subcommittee on Health and the Environment — which was the same subcommittee responsible for holding hearings on the 1974 Act in the House — was the Undersecretary of the Department of Health, Education and Welfare, the agency primarily responsible for administering the 1974 Act. Undersecretary Hale Champion was there to present the

views of his agency on the proposed amendments to the Planning Act, and during his testimony, the following instructive dialogue occurred:

> Mr. Lee. The question concerning antitrust implications, could you comment on that? Do we need to exempt HSA's? There seem to be too few legal precedents on the surface to make that kind of judgment.
>
> Mr. Champion. Our view is that the concern . . . is misplaced. The problem of antitrust here is if the agency attempts to delegate its responsibility to some group by saying to hospitals, you divide up this responsibility. If the agency itself considers the questions and makes the decisions based on an institution's specific kind of data, then we don't think there are any antitrust questions involved.
>
> It is only when there is an indication that the decision was reached by letting some providers get together and allocate functions. But if the agency looks at it, makes a decision based on its own review, and doesn't delegate the responsibility to a group of providers, then there aren't antitrust questions.
>
> I think in some cases there has been an effort to make people more worried about that subject than they ought to be. That is our present view. [Health Planning and Resources Development Amendments of 1979: Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on H.R. 3041 and H.R. 3107, 96th Cong., 1st Sess. 161 (1979) (hereinafter "Hearings on 1979 Health Planning Amendments")].

If the Congress in 1974 intended to repeal the antitrust laws, this significant fact had obviously escaped the attention of both the agency administering the Planning Act and the subcommittee responsible for the legislation.

The testimony of private witnesses on the 1979 Amendments similarly negates any notion that they believed that antitrust laws had been repealed by the 1974 Act. The American Health Planning Association urged the addition of an antitrust exemption for planning agencies and those "who voluntarily follow the recommendations of a SHPDA or HSA . . . ." Hearings on 1979 Health Planning Amendments, at 188. The American Medical Association recommended that "actions taken in meeting the requirements of the Act" be exempt from the antitrust laws. *Id.* at 641. The Health Insurance Association of America urged that Congress "make clear that the health planning agencies in the execution of their responsibilities concerning voluntary conversion, closure, reduction of capacity, and development of multi-institutional systems are exempt from antitrust action if those activities are carried out in compliance with the planning law." *Id.* at 671. The Central Virginia Health Systems Agency suggested that Congress "exempt HSAs and providers who voluntarily work with them in carrying out the HSA's statutory authority from the anti-trust laws." *Id.* at 701. This record of continual suggestions for *explicit* antitrust exemptions cannot be reconciled with the argument that Congress had, just five years earlier, created an *implied* antitrust exemption. Certainly those most active in the field had no such understanding in 1979.

The Congressional discussions are even more revealing. The Senate Report, in discussing the inclusion of the "strengthening of competitive forces in the health services industry" as an additional health priority, expressed concern about the creation of "industry cartels which emphasize market stability rather than innovation and consumer preference," and served notice that it "intends to protect against such tendencies in health sector

regulation." S. Rep. No. 96, 96th Cong., 1st Sess. 85, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1390. The House Report devoted over five pages to "The Role of Competition . . . and the Application of the Antitrust Laws . . .," seeking, in its words, "to explain the appropriate relationship between [the 1974 Act] and the antitrust laws and the appropriate interaction between health planning and competition." H.R. Rep. No. 190, 96th Cong., 1st Sess. 51 (1979). Neither report contains even a single reference to antitrust immunity for private parties "cooperating" with planning agencies. It strains credulity to imagine that the 1974 Congressional intention respondents see so clearly in 1981 was never mentioned or even alluded to in 1979.

What Congress actually did in 1979 is also instructive. The 1974 Act included a limited exemption from private damage actions for individual members and employees of HSAs; there was no mention of any exemption for private parties outside of HSAs. As we have seen, the scope of this exemption was a major issue in 1979. Several recommendations would have extended the statute's express immunity to include private parties "cooperating" with planning agencies. Congress rejected those suggestions, broadening the express exemption only to include the HSA itself and to include a good faith defense for HSA employees and members. No exemption was provided for private parties, nor is there one iota of evidence that Congress thought such an exemption was unnecessary because it already existed.

III. THE NOTION OF ANTITRUST IMMUNITY WITHOUT EFFECTIVE PUBLIC SUPERVISION FINDS NO SUPPORT IN PRIOR DECISIONS OF THIS COURT.

There is no doubt that federal and state governments, within the concept of federalism set forth in the Constitution, can restrain competition and restrict market liberty. Where the power to restrain competition is consigned to private interests with economic stakes in the outcome, however, serious constitutional questions are raised. *See, e.g., Schechter Corp.* v. *United States,* 295 U.S. 495 (improper delegation of legislative powers); *Gibson* v. *Berryhill,* 411 U.S. 564, 578-79 (regulation by those with pecuniary interest in the outcome is denial of due process).[7]

This same issue — the delegation of government power — has also been faced in the context of the "state action" exemption cases (which respondents, for obvious reasons, argue are not relevant).[8] Under the "state ac-

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[7] Respondents in effect argue that Congress in enacting the 1974 Planning Act intended to delegate to private parties unlimited power to adopt whatever measures they thought conducive to furthering the general congressional goals of "restraining increases in the cost of providing . . . health services," and "preventing unnecessary duplication of health resources." 42 U.S.C. §300*l*-2(a)(3)&(4). If this is so, the delegated power here, like that in *Schechter*, is, in Justice Cardozo's words, "not canalized within banks that keep it from overflowing." Rather, it is "unconfined and vagrant," unrestrained by any standard to which it must conform (295 U.S. at 551-52, Cardozo, J., concurring.) *See also Carter* v. *Carter Coal Co.*, 298 U.S. 238, 311.

[8] Respondents' protests of irrelevance (R. Br. at 29, 35) ignore the fact that the only *regulatory* scheme established by the 1974 Act was a scheme of state regulation. Respondent argues that "[t]o require compulsion as a prerequisite to antitrust immunity here would be to destroy the chances for any regulatory scheme based on

tion" doctrine, it is not enough that market restraints are "prompted" by the State as sovereign or imposed by "state agenc[ies] for limited purposes." *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 791. Rather the sovereign command must be clear and subject to the "pointed re-examination" of authorized public bodies. *Bates* v. *State Bar of Arizona,* 433 U.S. 350, 362.

That does not mean that interested private parties cannot have an important voice in a market-restraining regulatory process. Government depends, in many cases, on access to information from private parties, *see Eastern Railroad Presidents Conference* v. *Noerr Motor Freight, Inc.,* 365 U.S. 127, 137, and a public scheme of regulation is not barred merely because it is triggered by private action, *see Parker* v. *Brown,* 317 U.S. 341; *New Motor Vehicle Board of California* v. *Orrin W. Fox Co.,* 439 U.S. 96. Yet in the end, there must be a clear *public* mandate and clear *public* supervision. *California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.,* 445 U.S. 97. This is not, as this short discussion shows, an isolated legal principle, but a basic application of the rule of law — which abhors the vigilante tradition.[9] It is

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cooperative implementation ever to succeed." (R. Br. at 35). But is this anything more than the discredited notion that to require active supervision by the State would destroy the opportunity to "give immunity to those who violate the Sherman Act by authorizing them to violate it. . . ."? *See Parker* v. *Brown,* 317 U.S. 341, 351; *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.,* 445 U.S. 97. "Cooperative implementation," as that phrase is used by respondents, is directly inconsistent with the language and spirit of the antitrust laws and, like the attempted delegation of governmental power to private parties by the States, should not be countenanced by this Court in the absence of "clear and manifest" evidence that Congress intended such a result. *See* authorities cited, Pet. Br. at 14. No such evidence can be found here.

[9] Respondents claim that this case is "worlds apart from *Fashion Originators Guild* v. *FTC,* 312 U.S. 457, where an industry group

also the teaching of the federal implied immunity cases which, even when they find immunity, turn on the responsibility, role and supervision of the *public* actor.

Respondents seek to find support in *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, and *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659. Petitioner agrees these are useful comparisons, although they compel quite a different conclusion from that urged by respondents. In *NASD*, the Court was faced with a statute which "vests in the SEC broad regulatory authority over the business practices of investment companies." 422 U.S. at 704-05 & n.13. In that context, and after a very careful review of the language and legislative history of the statute involved, the Court concluded that the agreements challenged as violations were contemplated by Congress when it enacted the legislation, "for we see no way to reconcile *the Commission's power to authorize these restrictions* with the competing mandate of the antitrust laws." 422 U.S. at 722, emphasis added. The Court reasoned that (422 U.S. at 729-30):

> Congress had made a judgment that these restrictions on competition might be necessitated by the

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acted as legislature, judge and jury." R. Br. at 39. Yet, that is exactly what Blue Cross did. By respondents' own admission, Blue Cross was an active member of MAHSA, and itself helped develop the Health Systems Plan, which provided the "standards" by which Blue Cross sought to bar National Gerimedical's entry into the market. R. Br. at 38. Much though respondents would like to have this Court conclude that they were merely implementing independently-arrived-at community standards (R. Br. at 39), Blue Cross itself had a major role in helping to draw up those standards. Under these circumstances, to argue that Blue Cross' activity was passive, and directed only to implementing need standards independently arrived at by MAHSA, is disingenuous. In short, Blue Cross is acting, in a very real sense, as "legislature, judge and jury."

> unique problems of the mutual-fund industry, and has vested in the SEC final authority to determine whether and to what extent they should be tolerated 'in the interests of the holders of all the outstanding securities' of mutual funds.
>
> The SEC, *the federal agency responsible for regulating the conduct of the mutual-fund industry,* urges that *its authority* will be compromised seriously if these agreements are deemed actionable under the Sherman Act. We agree. There can be no reconciliation of *its authority under §22(f) to permit* these and similar restrictive agreements with the Sherman Act's declaration that they are illegal *per se.* In this instance the antitrust laws must give way if the regulatory scheme established by the Investment Company Act is to work. *Silver* v. *New York Stock Exchange,* 373 U.S. 341 (1963). [Emphasis added, footnote and citation omitted.]

Thus, the key fact was the authority of the SEC, a public agency, to oversee and regulate the conduct under attack. Respondents' attempt to equate MAHSA to the SEC is not convincing. The SEC is a federal agency invested with broad regulatory powers; MAHSA is a private corporation, comprised of providers, consumers and other interest groups, with no regulatory powers of any kind.[10] The SEC has the power to promulgate rules

[10] In 1979, Congress added new conflict of interest provisions to those already in the Planning Act to prevent providers from voting on matters before an HSA in which they had a financial interest. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §113(b), 93 Stat. 606, codified at 42 U.S.C. §300m-3(e) (Supp. III 1979). The concerns underlying this and earlier similar actions illustrate the fundamentally different character of an HSA from that of a public agency like the SEC. These concerns would be superfluous if Congress was trying to encourage private unsupervised arrangements by providers and others. Conflict of interest provisions are minor matters indeed if private collusion is to be the order of the day.

and regulations, and impose its will on those subject to its mandate; MAHSA has no power to do anything other than collect data and make recommendations. To the extent the 1974 Act created any regulatory agency, it is the SHPDA; under the Act, only the SHPDA can bar entry or expansion, and then only through application of the State certificate of need statute. The argument that the application of the antitrust laws would impose conflicting or inconsistent standards on Blue Cross is particularly disingenuous here, where the State — the only entity with any power under the legislative scheme to impose any standards on anyone — at the relevant time imposed no requirements and has now approved the very conduct that Blue Cross is seeking to impede.[11]

Nor is *Gordon* helpful to respondents' position. There again the Court was faced with legislation providing "explicit statutory authorization for SEC review of all exchange rules and practices dealing with rates of commission and resultant SEC continuing activity." 422

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[11] The assertion by respondents that "[p]etitioner cannot escape the provisions of the 1974 Act merely because the State of Missouri hesitated in enacting its own legislation" (R. Br. at 29) emphasizes the difficulties inherent in respondents' argument. The State of Missouri, like all other states, had the option to create a certificate of need program or face loss of federal funds. Until 1978, when it adopted certificate of need legislation, Missouri chose the latter course. Respondents are forced to argue, despite this choice by the State of Missouri and despite the fact that when Missouri did promulgate certificate of need legislation it granted approval to petitioner, that Congress intended a purely private group of individuals and entities to have the power, with no oversight or review by any public body, to veto decisions made by the State of Missouri in its sovereign capacity. For respondents to prevail, this Court must accept not only that this is what Congress intended, but that it created such a peculiar program without ever once debating its merits.

U.S. at 685. The very language quoted by respondents (R. Br. at 37), with changed emphasis, clearly illustrates the difference between that situation and the one here (422 U.S. at 689-90):

> It is clear . . . that the commission rate practices of the exchanges *have been subjected to the scrutiny and approval of the SEC.* If antitrust courts were to impose different standards or requirements, the exchanges might find themselves unable to proceed without violation of the mandate of the courts *or of the SEC.* Such different standards are likely to result because the sole aim of antitrust legislation is to protect competition, whereas the SEC must consider, in addition, the economic health of the investors, the exchanges, and the securities industry. *Given the expertise of the SEC, the confidence the Congress has placed in the agency, and the active roles the SEC and the Congress have taken,* permitting courts throughout the country to conduct their own antitrust proceedings would conflict with the regulatory scheme authorized by Congress rather than supplement that scheme. [Emphasis added; footnotes omitted].

Here, by contrast, there is no agency able to examine or approve the conduct in question; there has been no scrutiny of any kind of the boycott by Blue Cross, much less any approval by any public agency; no mandate of any public agency requires Blue Cross' conduct; there are no "different standards"; and there is no possibility that antitrust enforcement against private collusive conduct in such circumstances would "conflict with the regulatory scheme authorized by Congress."

In *NASD* and *Gordon*, the Court was faced with antitrust attacks on self-regulatory schemes clearly and affirmatively accepted by Congress, subject to the active and continuing oversight of a public agency with the power to approve, prohibit or alter the actions complain-

ed of. Here, there is no such scheme of self-regulation; there is no public agency with the power to approve or regulate in any way the conduct complained of; and respondents concede that their actions were volitional and independent of any regulatory compulsion. These differences are critical, and thus *NASD* and *Gordon* provide no support for a conclusion of implied repeal.

CONCLUSION

Congress never exempted the conduct at issue from the antitrust laws, either explicitly or by implication. The judgment below should be reversed.

Respectfully submitted,

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APPENDIX

APPENDIX

Relevant Statutory Provisions Of The National Health Planning And Resources Development Act Of 1974
[Excerpted from the 1976 Codification of the Act, 42 U.S.C. §§300k *et seq.* (1976)]

Section 300*l*-1(b)(1)

(b) Legal structure; staff; governing body; responsibilities; composition; limitation of individual liability; acceptance of contributions; reports

(1) A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before January 4, 1975) to carry out health planning and review functions such as those described in section 300*l*-2 of this title, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

Section 300*l*-2(b)

(b) Health Systems and Annual Implementation Plans; establishment; review

In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning—

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities

(E) the patterns of utilization of the area's health resources, and

(F) The environmental and occupational exposure factors affecting immediate and long-term health conditions.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 242k(e) of this title

(2) the agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 300k-1 of this title, the priorities set forth in section 300k-2 of this title, and the data developed pursuant to paragraph (1), establish, annually review, and amend as necessary a health systems plan (hereinafter in this subchapter referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will

assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; and (C) which take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 300k-1 of this title respecting supply, distribution, and organization of health resources and services. Before establishing an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP.

(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this subchapter referred to as the "AIP") which describes objectives which will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the costs of attaining such objectives to their benefits, and which are fitted to the special needs of the area.

(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

Section 300*l*-2(f)

(f) Recommendations for new institutional health services.

To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 300m-2(a) of this title each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the service area of such health systems agency.

Section 300*l*-2(g)(1) and (2)

(g) Institutional health services, review

(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 300m of this title for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 300*l*-4(c) of this title

Section 300*l*-2(h)

(h) Recommendations of projects to state health planning and development agencies

Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects

Section 300m

§300m. Designation of State health planning and development agencies

(a) Authority of Secretary to enter into agreements

For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m-2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) of this section enter into, continue in effect, or renew such an agreement.

(b) State administrative program; Governor as the authority to select agency; requirements; conditional designation; period of agreement; termination; designation of State agency for the State; termination and renewal

(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (herinafter in this part referred to as the "State Agency") to administer the State administrative program prescribed by section 300m-1 of this title and to carry out the State's health planning and development functions prescribed by section 300m-2 of this title. The Secretary may not enter into such an agreement with the Governor of a State unless —

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m-2 of this title, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 300m-3 of this title.

(2)(A) The agreement entered into with a Governor of a State under subsection (a) of this section may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m-2 of this title. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

(B) The period of an agreement described in subparagraph (A) may not exceed twenty-four months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 300m-2 of this title as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3),

(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety day's notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the

responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed twelve months, except that, prior to the expiration of such term, such agreement may be terminated —

(A) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement. An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed twelve months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the applicable State administrative program continues to meet the requirements of section 300m-1 of this title.

(c) Agreements for substitution

If a designation agreement with the Governor of a State entered into under subsection (b)(2) or (b)(3) of this section is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

(d) Suspension of grants

If, upon the expiration of the fourth fiscal year which begins after 1975, an agreement under this section for the

designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this chapter, the Community Mental Health Centers Act [42 U.S.C. 2689 et seq.], or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [42 U.S.C. 4541 et seq.] for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect.

Section 300m

§300m. Designation of State health planning and development agencies

(a) Authority of Secretary to enter into agreements

For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m-2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) of this section enter into, continue in effect, or renew such an agreement.

(b)State administrative program; Governor as the authority to select agency; requirements; conditional designation; period of agreement; termination; designation of State agency for the State; termination and renewal

(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this part referred to as the "State Agency") to administer the State administrative program prescribed by section 300m-1 of this title and to carry out the State's health planning and development functions prescribed by section 300m-2 of this title. The Secretary may not enter into such an agreement with the Governor of a State unless —

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m-2 of this title, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 300m-3 of this title.

Section 300m-1

§300m-1. State administrative program

(a) Conditions for approval by Secretary

A State administrative program (hereinafter in this section referred to as the "State Program") is a program for the performance within the State by its State Agency of the functions prescribed by Section 300m-2 of this title. The Secretary may not approve a State Program for a State unless it —

(1) meets the requirements of subsection (b) of this section;

(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

(b) Requisite features of program

The State Program of a State must —

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 300m-2 of this title and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

(3) provide for adequate consultation with, and authority for, the Statewide Health Coordinating Council (prescribed by section 300m-3 of this title), in carrying out such functions and the State Program;

(4)(A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe.

(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 4728(a) of this title, but

the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(5) require the State Agency to preform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 300n-1 of this title;

(6) require the State Agency to (A) conduct its business meetings in public,(B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

(7) (A) Provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 242k(e) of this title of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

(10) require the State Agency to make such reports, in such form and containing such information, con-

cerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this subchapter;

(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this subchapter; and

(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 300m-2(a) of this title or under subchapter XIV of this chapter which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 300*l*-2 of this title by a health systems agency within the State —

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

(B) the decision of the reviewing agency shall for purposes of this subchapter and subchapter XIV of this chapter be considered the decision of the State health planning and development agency.

(c) Review by Secretary

The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b) of this section. The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year.

Section 300m-2

§300m-2. State health planning and development functions

(a) Performance by State agency of a State designated under section 300m(b) (3) of this title.

Each State Agency of a State designated under section 300m(b)(3) of this title shall, except as authorized under subsection (b) of this section, perform within the State the following functions:

(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 300m-3(c)(2) of this title) and the plans of the health systems agencies within the State which relate to the government of the State.

(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with state-wide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 300m-3(c) of this title.

(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 300o-2 of this title, and in the performance of its functions generally.

(4)(A) Serve as the designated planning agency of the State for the purpose of section 1320a-1 of this title if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 3001-2(f) of this title.

(5) After consideration of recommendations submitted by health systems agencies under section 300*l*-2(f) of this title respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health systems agencies under section 300*l*-2(g) of this title respecting the appropriateness of such services, make public its findings.

(b) Performance by other State agencies

(1) Any function described in subsection (a) of this section may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) of this section shall not apply to a State

Agency of a State until the expiration of the first regular session of the legislature of such State which begins after January 4, 1975.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date of a health systems agency has made its recommendation under section 300*l*-2(g) of this title with respect to the appropriateness of the service.

(c) Statement

If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6), or (7) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.